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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G127	A. BUILDING _____ B. WING _____	10/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from October 10, 2007 through October 12, 2007. A random sample of two clients was selected from a client population of four male clients with varying degrees of disabilities. The survey was completed using the fundamental survey process. The findings of this survey were based on observations at the group home and two day program, interview with day program consultants and residential staff, and a review of the habilitation and administrative records.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body failed to provided general operating direction over the facility as described in the following: 1. The Governing Body failed to have an effective system for nursing personnel to monitor Trained Medication Employees to ensure accurate documentation of medication administration as detailed in the agencies nursing policy and procedures. [See W189 and W365] 2. The Governing Body failed to ensure that nursing staff followed agency nursing protocol in accordance with the agency's policy and procedures. [See W331, W322, W371, W381 and W382]	W 104	The Director of Health Services has provided all medication nurses and TME's addition training on accurate documentation of medication administration. Training was completed on 10/30/2007. The delegating RN will review the MAR at least once weekly monitor documentation. The Director of Health Services will conduct a routine QA of the client medical administration records and provided the follow-up as necessary to ensure accurate documentation of medication administration and nursing compliance with established protocols.	10/30/07-Ongoing
W 120	483.410(d)(3) SERVICES PROVIDED WITH	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/5/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based observation, staff interview and record review, the facility failed to ensure that the day program met the needs of two of the two clients in the sample. (Client #1 and #2) The findings include: The facility failed to ensure that Client #1 and #2's repositioning protocols were being implemented at their day programs as evidenced below: 1. Direct care staff throughout the survey was observed repositioning Client #1. The Client was allowed to stand with staff assistance, to sit with his legs elevated, to sit on the couch and to lay down in his bed. Interview with the direct care staff and the Qualified Mental Retardation Professional on October 11, 2007 at approximately 1:40 PM revealed that Client #1 had a repositioning protocol in place for the purpose of reducing skin irritation and breakdown. Further interview with the QMRP revealed that she had not presented this protocol to the day program or provided training to the day program to ensure that this procedure was being implemented at the day program. Review of the Individual Program Plan on October 11, 2007 at 2:00 PM revealed that Client #1 was required to be "repositioned every two	W 120	1-2. The QMRP has provided training to day program staff on the repositioning protocol for Client # 1. Training verification has been placed in client #1 record. QMRP has also provided the day program with a repositioning data sheet which will be returned to the residential program on a weekly basis and filed in Client #1 and #2 record. The day program has been provided with a copy current Health Management Care Plan which specifically details skin integrity and repositioning protocols.	11/01/2007 – Ongoing

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W 120	Continued From page 2 hours when he is awake to relief stress on the delicate skin in his sacral area." The protocol also included a repositioning check sheet for data to be record when implementing this protocol. Review of the records did not evidence any repositioning data from Client #1's day program. 2. On October 10 and 11, 2007 direct care staff was observed throughout the survey repositioning Client #2. The Client was allowed to stand and to ambulate with his walker, to sit on the couch and to sit in a regular chair during his meals. Interview with the direct care staff and the Qualified Mental Retardation Professional on October 11, 2007 at approximately 3:00 PM revealed that the client had a repositioning protocol for the purpose of reducing skin irritation and breakdown. Further interview with the QMRP revealed that she had not presented this protocol to the day program and/or provided training to the day program to ensure that this procedure was being implemented at his day program. Review of the Individual Program Plan on October 11, 2007 at 2:00 PM revealed that Client #1 was to "stand for two minutes every hour hours when he is awake to relief stress on the delicate skin in his sacral area." The protocol referred to a repositioning data check sheet. Review of the habilitation records, however did not evidence the repositioning data check sheet from the day program. Review of the day program Plan of Care dated 2/23/07 did not detail any skin integrity concerns and did not address repositioning. There was no evidence that the day program had been made aware of the group homes plan to address Client #2's concern to	W 120	See responses to W120 on page 2/32 Additionally the QMRP will communicate all relevant information regarding changes in programming for Client #1 to ensure that the day program meets the needs of Client #1 and #2. The Director of Programs will conduct routine record audits to verify compliance.	11/01/2007 – Ongoing

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W 120	Continued From page 3 reduce skin irritation and skin breakdown. According the Physical Therapy (PT) evaluation dated 11/15/06 skin breakdown was an ongoing problem and needed ongoing monitoring.	W 120	See responses to W120 on page 2/32	
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and review of records, the facility failed to establish and maintain a system that ensures a complete and accurate accounting of clients' funds that are entrusted to the facility for three of the four clients residing in the facility. (Client #1, #2 and #4) The findings include: The facility failed to ensure accurate and complete accounting of each clients personal funds. 1. On October 12, 2007 at approximately 2:00 PM, interview with the QMRP and review of Client #1 personal bank statement revealed that on August 15, 2007 a withdrawal of $475.00 was made from the client's account. Further review of the records did not evidence any receipt(s) to verify how his monies were used. Interview with the QMRP revealed that the system requires that the receipts are taken to their main office and reconciled. Further interview revealed that she could not verify with documentation what the monies were used.	W 140	1. The Residence Manager has submitted original receipts for the $475.00 withdrawn from Client #1's bank account on 8/15/2007. the receipts have been placed on file in the Administrative office in Client #1's file. The Residence Manager will reconcile all withdrawals from Client #1's within thirty days of the withdrawal of funds	10/22/2007 - ongoing

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W 140	Continued From page 4 2. On October 12, 2007 at approximately 2:10 PM, interview with the QMRP and review of Client #2 personal bank statement revealed that on August 15, 2007 a withdrawal of $465.00 was made from the client's account. Further review of the records did not evidence any receipt(s) to verify how his monies were used. Interview with the QMRP revealed that the system requires that the receipts are taken to their main office and reconciled. Further interview revealed that she could not verify with documentation what the monies were used. 3. On October 12, 2007 at approximately 2:20 PM, interview with the QMRP and review of Client #4 personal bank statement revealed that on August 15, 2007 a withdrawal of $300.00 was made from the client's account. Further review of the records did not evidence any receipt(s) to verify how his monies were used. Interview with the QMRP revealed that the system requires that the receipts are taken to their main office and reconciled. Further interview revealed that she could not verify with documentation what the monies were used.	W 140	2. The Residence Manager has submitted original receipts for the $465.00 withdrawn from Client #2's bank account on 8/15/2007. The receipts have been placed on file in the Administrative office in Client #2's file. The Residence Manager will reconcile all withdrawals from Client #2's within thirty days of the withdrawal of funds 3. The Residence Manager has submitted original receipts for the $300.00 withdrawn from Client #4's bank account on 8/15/2007. The receipts have been placed on file in the Administrative office in Client #4's file. The Residence Manager will reconcile all withdrawals from Client #4's within thirty days of the withdrawal of funds 1-3 Additionally the QMRP will audit all reconciliations of client funds and verify all purchases prior to submission of receipts to Administrative Office. A tracking sheet for all withdrawals has been implemented and will be forwarded to the Program Director for follow-up and further action as necessary, prior to reconciliation due date.	10/22/2007 - ongoing 11/01/07 – Ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	W 153	See response to W153 on page 6/32	

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W 153	Continued From page 5 facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) The finding includes: The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on October 10, 2007 at 9:45 AM, revealed the facility failed to report the following incident(s) to the administrator or to the governmental agency. a. An unusual incident report, dated July 8, 2007, revealed Client #1 face was observed by the staff to be swollen. There was no additional information available to determine the unknown origin of this injury. b. An unusual incident report, dated October 12, 2006, revealed Client #1 was being assisted during personal hygiene and slide off the bed onto the floor in his bedroom. There was no additional information available to determine if staff were negligent or if theere were any injuries. c. An unusual incident report, dated June 26, 2007, revealed Client #4 arrived from his day program with "scars on and near his ear and neck". There was no additional information available to determine the unknown origin of these injuries. d. An unusual incident report, dated November 11, 2006, revealed Client #1 was discovered with his right finger bleeding. There was no additional information available to determine the origin of	W 153	a. The unusual incident report for client #1 dated July 8, 2007 has been investigated. Review of records indicates that Client #1 was evaluated by the nurse on 07/08/2007 nursing notes state there was no apparent injury. Supporting documentation of this incident is maintained in Client #1's records. Staff received additional training on incident management, which included the incident reporting process. b. The unusual incident report for Client #1 dated October 12, 2006 has been investigated. Review of the records indicated that there were no injuries sustained to Client #1 as a result of him sliding off the bed. Staff completed an incident report as a precautionary measure until he had been fully evaluated by a health care professional. Staff received training to reinforce appropriate lifting and transferring techniques. c. The unusual incident report for Client #4 dated June 26, 2007 has been investigated. Supporting documentation is maintained in client #4's record. The results of the investigation revealed that Client #4 had sustained the injury while at the day program. The origin of the injury was determined as a result of reviewing day program record for Client #4 and discussion with staff at the day program. d. The unusual incident report for client #1 dated November 11, 2006 has been investigated. Results of the investigation determined that the injury was sustained by the blinds in client #1's bedroom. To prevent further injury the bedroom furniture was repositioned. To date there have been no similar recurrence. a-d Additionally, QMRP will ensure that all incidents reports are generated to all pertinent parties and investigated according to policy and procedure. The Incident Management Coordinator will review all incidents and follow-up to ensure agency adherence to incident management policy and procedures. A tracking system has been implemented to monitor timely submission of investigative reports and pertinent documentation regarding the incident.	11/01/07 – Ongoing 11/01/07 – Ongoing 11/01/07 – ongoing 11/01/07 – Ongoing Ongoing

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W 153	Continued From page 6 this injury.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure all unusual incidences of injuries of unknown origin were thoroughly investigated. The findings include: Review of the facility's Unusual Incident Reports log book on October 10, 2007 at 9:45 PM revealed the following incidents and/or injuries of unknown origin were not been investigated: a. An unusual incident report, dated July 8, 2007, revealed Client #1 face was observed by staff to be swollen. There was no further information available to determine the origin of this injury. b. An unusual incident report, dated October 12, 2007, revealed Client #1 was being assisted during personal hygiene and fell off the bed to the floor in his bedroom. There was no further information available to determine if staff were negligent or in there was an injuries. c. An unusual incident report, dated June 26, 2007, revealed Client #4 arrived from his day program with "scars on and near his ear and neck". There was no further information available to determine the origin of these injuries.	W 154	a-c. Cross reference response to W153.	11/01/07 – Ongoing

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W 154	Continued From page 7 d. An unusual incident report, dated November 11, 2006, revealed Client #1 was discovered with his right finger bleeding. There was no further information available to determine the origin of this injury.	W 154	d Cross reference response to W153.	11/01/07 – Ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment. The findings include: 1. The QMRP failed to coordinate outside services and supports for Client #1 and #2. a. Throughout the survey direct care staff was observed repositioning Client #1. The Client was allowed to stand with staff assistance, to sit with his legs elevated, to sit on the couch and to lay down in his bed. Interview with the direct care staff and the Qualified Mental Retardation Professional on October 11, 2007 at approximately 1:40 PM revealed that Client #1 had a repositioning protocol in place for the purpose of reducing skin irritation and breakdown. Further interview with the QMRP revealed that she had not presented this protocol to the day program or provided	W 159	1a-b. Cross reference response to W120 #1-2.	10/14/07- Ongoing

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W 159	Continued From page 8 training to the day program to ensure that this procedure was being implemented at the day program. Review of the Individual Program Plan on October 11, 2007 at 2:00 PM revealed that Client #1 was required to be "repositioned every two hours when he is awake to relief stress on the delicate skin in his sacral area." The protocol also included a repositioning check sheet for data to be record when implementing this protocol. Review of the records did not evidence any repositioning data from Client #1's day program. b. On October 10 and 11, 2007 direct care staff was observed throughout the survey repositioning Client #2. The Client was allowed to stand and to ambulate with his walker, to sit on the couch and to sit in a regular chair during his meals. Interview with the direct care staff and the Qualified Mental Retardation Professional on October 11, 2007 at approximately 3:00 PM revealed that the client had a repositioning protocol for the purpose of reducing skin irritation and breakdown. Further interview with the QMRP revealed that she had not presented this protocol to the day program and/or provided training to the day program to ensure that this procedure was being implemented at his day program. Review of the Individual Program Plan on October 11, 2007 at 2:00 PM revealed that Client #1 was to "stand for two minutes every hour hours when he is awake to relief stress on the delicate skin in his sacral area." The protocol referred to a repositioning data check sheet. Review of the habilitation records, however did	W 159		

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W 159	Continued From page 9 not evidence the repositioning data check sheet from the day program. Review of the day program Plan of Care dated 2/23/07 did not detail any skin integrity concerns and did not address repositioning. There was no evidence that the day program had been made aware of the group homes plan to address Client #2's concern to reduce skin irritation and skin breakdown. According the Physical Therapy (PT) evaluation dated 11/15/06 skin breakdown was an ongoing problem and needed ongoing monitoring. c. October 11, 2007 at approximately 12:45 PM interview with the day program Nurse and the Program Director revealed that they were in need of Client #2's current physician's orders from group home. Further interview with the nurse revealed that Client #2 did not receive medications at his day program, however, the nurse insisted that current medical information is needed on file in case of an emergency situation. Interview with the QMRP later that same afternoon (approximately 2:30 PM) revealed that Client #2's physician orders had been delivered to his day program on several occasion. Although, the QMRP stated that she delivered the physician's orders to Client #2's day program, she was unable to verify her delivery with documented evidence. 2. The QMRP failed to ensure diet orders were reflective of nutritional changes to Client #1's nutirtional recommendations. On October 11, 2007 at approximately 1:40 PM, interview with the nurse and the review of Client #1's physician's order dated 9/1/07 revealed a 1500 calorie high fiber, low fat, low cholesterol	W 159	c. The QMRP has provided the day program a copy of the current physician orders for Client #2. A receipt for delivery will be obtained for all documents provided to the day program. Current Physician Orders will be provided to the day program on an ongoing basis. Delivery receipts will be maintained as a record of theses transactions in client records. 1a-c. Additionally the QMRP will communicate all relevant information regarding changes in programming for Client #1 and #2. The Director Programs will conduct routine record audits to verify the QMRP in monitoring, integrating and coordinating each client's active treatment. 2. The nutritionist assessed client #1 on 10/14/07. All diet assessments were reviewed by the PCP on 10/15/07. All physician's order forms have been reviewed and revised to reflect the correct diet orders. QMRP in conjunction with the delegating nurse will audit the client records monthly and coordinate	11/01/07 – Ongoing 10/15/07- Ongoing

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W 159	Continued From page 10 diet. Further review of the order included prune juice or prunes for snacks, prune or apple juice daily and strictly follow nutritionist recommendations. There was no evidence that the nutritionist had assessed the client's since her April 11, 2007. Review of the April assessment recommended a diet order changed to 2000 - 2400 calories and bite size texture. These changes were not communicated to the primary care physician. 3. The QMRP failed to ensure that failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties. (See W189) 4. The QMRP failed to ensure that direct care staff documented topical treatment during activities of daily living. (See W365) 5. The QMRP failed to ensure that direct care documented on IPP program objectives consisitently. (See W252) 6. The QMRP failed to ensure that all unusual incidences of injuries of unknown origin were thoroughly investigated. (See W154) 7. The QMRP failed to ensure that the facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation. (See W153) 8. The QMRP failed to establish and maintain a system that ensures a complete and accurate accounting of clients' funds that are entrusted to	W 159	nutritional follow-up on a quarterly basis to ensure proper monitoring of Client's nutritional support needs. Additionally the QMRP in conjunction with the Delegating Nurse, will communicate all recommended nutritional changes to the PCP as they occur. The PCP will indicate review/approval by signing the nutritional assessment. The Delegating Nurse will update the Physicians Orders to reflect diet changes as they are approved by the PCP. 3. Cross reference response to W189 on page 12/32. 4. Cross reference response to W365 on page 23/32. 5. Cross reference response to W252 on page 16/32. 6-7. Cross reference response to W154 & W153 on pages 5 and 6 of 32. 8. Cross reference response to W120 on page 2/32.	11/01/07 – Ongoing 11/01/07 – Ongoing 11/01/07 – Ongoing 11/01/07 – Ongoing 11/01/07 – Ongoing

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W 159	Continued From page 11 the facility. (See W140) 9. The QMRP failed to ensure that the day program were trained in the implementation repositionig protocols for Client #1 and #2. (See W120)	W 159	9. Cross reference response to W120 on page 2/32.	11/01/07 – Ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The findings include: 1. The facility's direct care staff failed to be effectively trained to ensure that Client #3 was provided his adaptive gloves to protect his hands when propelling his wheelchair. Observation on October 10, and 11, 2007 revealed that Client #4 had the ability to mobilize his wheelchair independently. Interview with the staff and record review on October 12, 2007 revealed that Client #4 was to use protective gloves to reduce hand calloses. Interview with the house manager on October 11, 2007 at approximately 4:30 PM revealed that the adaptive support gloves were in the night stand in his bedroom.	W 189	1. Review of the training records indicated that staff had received training on the proper use of gloves for Client #4 including documenting refusals to wear the gloves. The use of gloves for Client #4 has been highlighted as a support need on his daily activity data sheet. The data sheet is maintained in his daily program record. Staff will document the use of gloves when Client #4 is propelling his wheelchair. Residence Manager in conjunction with QMRP will routinely observe Client #4 to ensure that gloves are used per PT recommendations.	11/01/07 – Ongoing

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W 189	Continued From page 12 Review of Client #3's Physical Therapy assessment dated October 4, 2006 revealed a recommendation to continue the use of gloves for wheelchair propulsion as a measure to decrease calluses. At no time during the survey were direct care staff observed to encourage Client #3 to wear his gloves. 2. The facility's direct care staff failed to be effectively trained to ensure that Client #1 and Client #3's elevated tray was consistently used during each meal. Observation of the breakfast on October 10, 2007 at 7:43 AM revealed Client #1 and Client #3 eating independently using an adaptive built-up handle spoon and a high sided plates. Also observed using the meal was a large amount of spillage on the counter surface. Observation of the dinner at approximately 4:52 PM revealed Clients #1 and #3 eating independently with their adaptive plante on an elevated wooden tray. There was minimal spillage observed. Interview with the house manager confirmed that both of these clients were required to use a wooden riser during meals to bring the plate closer to them and to reduce spillage while eating. Review of Client #1's Occupational Therapy (OT) assessment dated 12/5/06 revealed a recommendation to continue to use an elevated tray for meals to reduce spillage and distance from plate to mouth. Review of Client #3's OT assessment dated 12/5/06 recommended that	W 189	2. Staff have received additional training in the use of adaptive equipment at mealtimes for Client #1 and #3. The use of adaptive equipment for Client #1 and #3 has been highlighted as a support need on their daily activity data sheet. The data sheet is maintained in their daily program record. Staff will document the use of adaptive equipment at mealtimes. Residence Manager in conjunction with QMRP will routinely observe mealtimes to ensure that adaptive equipment is in use per OT recommendation.	11/01/07 – Ongoing

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W 189	Continued From page 13 he should also continue to use an elevated tray to reduce distance plate to mouth. 3. On October 12, 2007 at 11:00 AM interview with the house manager revealed that Client #1 was required to wear support ted hose daily. Further interview with the house manager revealed that the client was not wearing ted hose at that time, and stated that Client #1's support hose were in this bedroom's side table drawer. Review of the Physical Therapist assessment dated September 28, 2006 reflected a recommendation that the client wear supportive hose on his lower extremities to reduce swelling during waking hours. At no time during the survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg edema. 4. The Trained Medication Employee (TME) failed to implement agency nursing policy for disposal of Client #1's medication. Although the TME commented during the medication administration that he had participated in a TME training for his license renewal on the day prior to the survey, this training was not effective as evidenced by the following: Observation of the medication pass on October 10, 2007 at 8:03 AM, revealed that the Trained Medication Employee (TME) was unable to administer Client #1's all of his AM medication regimen. the TME was only able to administer Client #1 Lactulose 60 ml. The TME made three additional attempts were made to admininstere the remainder of his medications, but was	W 189	3. Staff have received additional training in the use of Support TED Hose daily for Client #1. The use of Support TED Hose for Client #1 has been highlighted as a support need on the daily activity data sheet. The data sheet is maintained in his daily program record. Staff will document the use of Support TED Hose daily. Residence Manager in conjunction with QMRP will routinely observe mealtimes to ensure that Support TED Hose is in use per PT recommendations. 4. The TME was provided additional instruction on appropriate mediation disposal on 10/17/07. The medication administration policy (which includes medication disposal procedures) is available at each home for staff reference. TME have been further instructed to contact the Delegating Nurse for clarification of procedures as necessary. Routine refresher courses will be provided to all staff certified to administer medications. The Delegating Nurse will perform routine medication pass observations to identify the need for further training. Follow-up action as appropriate will occur in the event of repeated deviation from the medication administration procedures including suspension of medication administration privileges.	10/17/07 – Ongoing 10/17/07- Ongoing

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W 189	Continued From page 14 unsuccessful. The TME turned to the surveyor during the medication pass and commented, "[Client #1] is refusing his medication". The TME proceeded to document in the Medication Administration Record (MAR) the clients refusal and left the unconsumed pills on the kitchen counter. The TME then picked up the telephone and reportedly contacted the nurse to report Client # 1 refusal of his medication. After completing his telephone conversation with the nurse, the TME placed the pills in the zip lock bag and placed the zip lock bag in the kitchen garbage container. Later that afternoon at 3:30 PM, interview with the Director of Nursing(DON) revealed that the agency policy of disposal of medication is to first document circle the date corresponding block on the front of the MAR indicating the medication was not given. Next, the TME was to write the reason for not giving the medication on the back of the MAR. Further interview with the nurse revealed that the TME has two options. 1) to secure and leave the medicaion for the nurse to destroy; or 2) to flush the medication down the drainage system and dcoumrnt it in the records.	W 189		
W 216	5. The facility failed to ensure that the day program was trained in the implementation Client #1 and #2 repositioning protocols. (See W120) 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	W 216	Cross reference response to W120 on page 2/32. See response to W216 on page 16/32.	11/01/07 – Ongoing

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W 216	Continued From page 15 facility failed to ensure that one of the two client in the sample had an annual physical health examination in preparation for his comprehensive functional assessment. (Clients #1) The finding includes: Interview with the Nurse on October 11, 2007 at approximately 1:30 PM and review of the medical records revealed that Client #1 last annual medical evaluation was completed on October 2, 2006. According to the nurse the client had been scheduled for the medical evaluation with the primary care physical and it had not occurred. According to further nurse's interview, the primary care physician was scheduled to come to the facility next week. Additionally the Individual Support Plan meeting was scheduled for 10/25/07. At the time of the survey, there was no documented evidence that Client #1's annual medical assessment had been completed.	W 216	The annual Physical examination was completed for Client #1 on 10/15/07. The physician has been provided with a calendar of all physical examination expiration dates to assist in ensuring timely examinations. The Delegating Nurse, in conjunction with the QMRP, will monitor the expiration dates of all physicals during her monthly nursing reviews and follow-up with the physician to schedule all physical appointments to their expiration.	10/15/07-Ongoing
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were documented consistently, accurately and in the frequency required by the IPP for two of the two clients included in the sample. (Clients #1 and #2)	W 252		

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W 252	Continued From page 16 The findings include: 1. The facility's medication nurse failed to document Client #2's participation in his self-medication objective consistently. (See W371) 2. Interview the house manager and record review on October 11, 2007 at 11:00 AM revealed Client #2 had an objective to"participate in an exercise program with 5 repetitions of each exercise for 5 days per week for 12 consecutive months" The program implementation was required daily. Review of the data sheets for the month of September reflected that direct care staff were not documenting data consistently as required by the data frequency schedule. 3. Interview the house manager and record review on October 11, 2007 at 11:20 AM revealed Client #2 had an objective to"walk twenty (20) feet in the residence every two (2) hours while awake using the roller walker for four(4) out of four (4) trails." The program implementation required the client participation on Monday, Wednesday and Friday. Review of the data sheets for the month of September reflected that direct care staff were not documenting data consistently as required by the data frequency schedule.	W 252	1. All medication nurses received additional training on completing the self-medication objective documentation on 10/30/07 for Client #2. All medication nurses will document the self-medication objective data as outlined in the individual self-medication assessment recommendations. The QMRP will review the data sheets weekly to monitor progress/participation in self-medication objectives. QMRP will include a report of progress in the monthly QMRP notes. The Delegating RN will monitor the completion of data during the weekly review of the MAR documentation. The Director of Health Services and Programs will audit the records to monitor for consistent documentation of the self medication objectives and follow up as necessary for any discrepancies noted. 2-3. Staff has received additional training on completing the documentation required for Client #2's exercise program on 10/27/07. Residence manager in conjunction with the QMRP will review data sheets weekly for consistent documentation and observe program implementation as required by data frequency schedule. Staff will be provided ongoing training to ensure that the documentation is recorded consistently. Evidence of review and observation will be reflected in the QMRP monthly progress note.	10/30/07-Ongoing 10/30/07-Ongoing
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and	W 264		

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W 264	Continued From page 17 programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility Human Rights Committee failed to reviewed, approved or monitor the use of bed rails for two of three clients in the sample (Clients #1 and #3. The finding includes: During the environmental walk-through on October 11, 2007 at approximately 5:30 PM, Clients #1 and #3 were observed to have bed rails on their beds. Interview with the house manager revealed that the bed rails were used when the client's were in their beds for their safety. Review of habilitation and medical records failed to provide the reason for using rails on clients #1 and #3's beds. At the time of the survey, HRC minutes were not available to determine if the bed rails had been reviewed, approved or monitor for Clients #1 and #3. Further review of the records did not evidence procedures for ensuring client safety while in a bed with bed rails. It should be noted that unusual incident reports revealed that Client #1 was found in bed with his finger bleeding and had to be taken to the emergency room for stiches and treatment.	W 264	The physician has reviewed the necessity of the use of bedrails for Client #1 and #3 and has recommended their continued use as a safety precaution. A procedure for ensuring client safety while in bed with bedrails has been developed and training will be provided on the protocol by the Physical therapist on 11/31/07. In the interim, staff received training on 10/17/07 that was conducted by the Delegating Nurse, on procedures for ensuring client safety while in bed with bedrails. The physician's recommendation for the use of bedrails has been reviewed and approved by the HRC on 10/29/07. The QMRP has received additional training on what situations require HRC review. QMRP will review all potential risks to the rights of the clients (including but not limited to the use of bedrails) with the established Human Rights Committee for recommendations, approval and monitoring. Evidence of the HRC review will be maintained in the Client's records and in the HRC records that are maintained in the administrative office.	10/29/07- Ongoing

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W 264	Continued From page 18 Another incident reported that Client #1 slide out of his bed onto the floor while direct care staff was assisting him with personal hygiene activities. [See W153] The facility's Human Rights Committee minute for the past 12 months were not available for review at the time of the recertification survey.	W 264	Additionally, the Director of Operations has developed an annual HRC committee meeting calendar and submitted it to all committee members. Minutes of all HRC meetings will be maintained by the Director of Operations in the administrative office. Copies of the HRC minutes will be distributed to the homes to be filed (as applicable) in all Client's record.	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventive care. The findings include: 1. The facility failed to ensure that Client #1's annual physical assessment was completed. (See W216) 2. Interview with the nurse and review of Client #2's medical records on October 11, 2007 at approximately 11:30 AM revealed an Ear, Nose and Throat (ENT) consultation occurred on March 20, 2007 with a recommendation to return September 2007. Further review of the medical records failed to reflect a follow-up appointment had been scheduled. 3. The facility failed to ensure that Client #1 was seen by a Dental consultant as required. (See W352) 4. The facility failed to ensure safety measures	W 322	1. Cross reference response to W216 on page 16/32. 2. A follow up ENT appointment for Client # 2 has been scheduled for 11/21/07. 3. The usual dental provider for Client #2 abruptly stopped accepting DC Medicaid. The agency provider has subsequently secured the services of an alternate dentist. Dental evaluation will be completed by 11/30/07 A list of dental providers has been secured as a reference to ensure uninterrupted dental service provision in the event that the current dental provider no longer accepts Client #2's benefits.	10/15/07-Ongoing 11/21/07-Ongoing 11/30/07-Ongoing

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W 322	Continued From page 19 were in place for theuse of Client #1 and #3 bed rails. During the environmental walk-through on October 11, 2007 at approximately 5:30 PM, Clients #1 and #3 were observed to have bed rails on their beds. Interview with the house manager revealed that the bed rails were used when the client's were in their beds for their safety. Review of habilitation and medical records failed to provide the reason for using rails on clients #1 and #3's beds. At the time of the survey, HRC minutes were not available to determine if the bed rails had been reviewed, approved or monitor for Clients #1 and #3. Further review of the records did not evidence procedures for ensuring client safety while in a bed with bed rails. It should be noted that unusual incident reports revealed that Client #1 was found in bed with his finger bleeding and had to be taken to the emergency room for stiches and treatment. Another incident reported that Client #1 slide out of his bed onto the floor while direct care staff was assisting him with personal hygiene activities. [See W153] 5. The facility's direct care staff failed to ensure that Client #3 was provided his adaptive gloves to protect his hands when propelling his wheelchair. Observation on October 10, and 11, 2007 revealed that Client #4 had the ability to mobilize his wheelchair independently. Interview with the staff and record review on October 12, 2007 revealed that Client #4 was to use protective gloves to reduce hand calloses.	W 322	1-3. Additionally, medical appointment completion will be monitored by the delegating RN at the monthly medical record review that is completed in conjunction with the QMRP and Residence Manager. During this meeting, the medical records of the Clients will be audited and the status of all medical follow will be reviewed and scheduled as applicable. A follow up response form has been implemented to communicate the status of action items identified at the monthly health services review meeting. A copy of this form is forwarded to the Directors of Health Services and Programs for review. Evidence of appointment completion will be forwarded to the delegating Nurse with a copy of the consultation filed in the client record. Appointment cancellations, delays or refusals will immediately be reported to the Delegating Nurse for further actions as necessary. 4. Reference response to W264 Cross reference response to W153 5. Cross reference response to W189 #1.	Ongoing 10/29/07-Ongoing

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W 322	Continued From page 20 Interview with the house manager on October 11, 2007 at approximately 4:30 PM revealed that the adaptive support gloves were in the night stand in his bedroom. Review of Client #3's Physical Therapy assessment dated October 4, 2006 revealed a recommendation to continue the use of gloves for wheelchair propulsion as a measure to decrease calluses. At no time during the survey were direct care staff observed to encourage Client #3 to wear his gloves. 6. On October 12, 2007 at 11:00 AM interview with the house manager revealed that Client #1 was required to wear support ted hose daily. Further interview with the house manager revealed that the client was not wearing ted hose at that time, and stated that Client #1's support hose were in this bedroom's side table drawer. Review of the Physical Therapist assessment dated September 28, 2006 reflected a recommendation that the client wear supportive hose on his lower extremities to reduce swelling during waking hours. At no time during the survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg edema.	W 322	6. Cross reference response to W189 #3.	Ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 331		

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W 331	Continued From page 21 review, the facility failed to provide nursing services in accordance with the needs of the clients residing in this facility. The findings include: 1. The facility's nursing staff failed to ensure that Client #2 had a ENT follow-up appointment scheduled. (See W322) 2. The facility nursing staff failed to ensure that Client #2's had a dental appointment scheduled. (See W352) 3. The facility's nursing staff failed to ensure that each client were provided usage of adaptive supports as recomended. (See W189 and W436)	W 331	1. Cross reference response to W322 #2. 2. Cross reference response to W322 #3. 3. Cross reference response to W189 and W436.	11/01/07 - Ongoing
W 343	483.460(d)(1) NURSING STAFF Nurses providing services in the facility must have a current license to practice in the State. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all nurses providing services in the facility had a current license to practice in the District of Columbia. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and the Supervising Nurse on October 11, 2007 at 4:00 PM indicated that the medication nurse had a current licensed in her consultant file. Review of the Nurse professional consultant files indicated that the nursing license had expired.	W 343	The professional license to practice in the District of Columbia for the LPN ([redacted]) has been obtained and is on file in a conspicuous manner per HORA guidelines. A copy of all Delegating Nurses, LPN's professional licenses will be maintained by the Director of Health Services. The Director of Health Services will maintain a spreadsheet of the expiration dates of all Nursing licenses. Notification of expiring, expired, or absent documents will be forwarded to the pertinent individuals along with a deadline for submission. In the event that the requested documentation is not submitted, consequential action as appropriate will occur including suspension of duties until such time that the required documents are submitted.	10/17/07- Ongoing

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W 343	Continued From page 22 There was no evidence that at the time of the survey that the LPN ([redacted]) had a current license to practice in the District of Columbia, in accordance with the Health Occupation Revision Act (HORA) Title 3 Chapter 12 Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.")	W 343		
W 352	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure a client received timely dental services for one of two sampled clients. [Client #2] The finding includes: Interview with the nurse and review of Client #2's medical records on October 11, 2007 at approximately 11:50 AM revealed his last dental consultation was completed March 21, 2005. Further interview with the nurse revealed that a April 13, 2007 and May 19, 2007 consultation forms were in the medical book, however the dental appointments were not completed.	W 352	Cross reference response to W322 #3 on page 19/32.	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client.	W 365		

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W 365	Continued From page 23 This STANDARD is not met as evidenced by: Based on staff interview and record reviews, the facility failed to establish and maintain a systems that ensures that an individuals medication records were maintained for two of the two in the sample. (Client #1 and #2) The findings include: 1. The facility failed to ensure its system for documentation of Client #1's medication administration in accordance with the agency's policy and procedures as evidence by the following: Review of Client #1's Medication Administration Record (MAR) after the medication pass observation on October 10, 2007 at approximately 8:45 AM revealed the following: a. On 10/7/07 the client's PM dosage of Senna Gel Tablets had not been signed as being administered. b. On 10/7/07 the client's PM dosage of Keppra 750mg had not been signed as being administered. c. On 10/7/07 the client's PM dosage of Valproic Acid 25 mg had not been signed as being administered. d. On 10/7/07 the client's PM dosage of Valproic Acid 25 mg had not been signed as being administered. e. On 10/7/07 the client's PM dosage of 60 ML of Lactulose had not been signed as being administered.	W 365	See response to W365 on page 24/32. 1a-g. The documentation errors for Client #1 and #2 were corrected on 10/15/2007. Review of the medication blister pack and interview with the staff revealed that the medication had been given but not documented on the MAR. The Director of Health Services has provided all medication nurses and TME's additional training on accurate documentation of medication administration. Staff have been instructed on correct procedures for documenting a medication omission on the MAR. Training was completed on 10/30/2007. The delegating RN will review the MAR at least once weekly to monitor documentation. Follow-up action as appropriate will occur in the event of repeated deviation from the approved medication administration procedures including suspension of medication administration privileges.	10/30/07-Ongoing

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W 365	Continued From page 24 f. On 10/7/07 the client's PM dosage of Aspirin 325 mg Valproic Acid 25 mg had not been signed as being administered. g. On 10/7/07 the client's PM topical treatment cleanser and warm compress had not been signed as being administered. Interview with the nurse on 10/11/07 at 11:00 AM revealed that there medication were administered on the evening of 10/7/07, however the nurse failed to document her administration. 2. The Trained Medication Employee (TME) failed to document Client #1's refusal of his medication correctly in the MAR in accordance with the agency policy and procedures. Interview with the designated nurse on 10/11/07 at approximately 2:45 PM revealed that the TME failed to document Client #1's refusal of his prescribed medication regimen in the progress section of the Medication Administration Records. Additionally, he administered Client #1 60 ml of Lactulose, however incorrectly documented this medication as if it had not been administered. According to the DON the TME was to have circled the the slot for the date refused and initial in the circle. Next he was to document on the back of the MAR and then write a progress note in order to communicate to the nurse to reordered medicatrion and adequately account for medications which were destroyed. 3. The facility failed to ensure its system for documentation of Client #1's topical treatment medication administered by the direct care staff	W 365	2. TME's have received further training on the proper disposal of wasted mediation and appropriate documentation procedures and have been reminded of the Medication Administration Training manual's location to use as a reference. Training was completed on 10/30/2007. The delegating RN will review the MAR at least once weekly to monitor documentation. Additionally, the residence has been provided with a medication administration reference manual. Follow-up action as appropriate will occur in the event of repeated deviation from the approved medication administration procedures including suspension of medication administration privileges	10/30/07-Ongoing

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W 365	Continued From page 25 were implemented in accordance with the agency's policy and procedures as evidenced below: June 2007 Ammonium Lactate 12% Cream(GM) Apply to legs every day at 7:00 AM - 30 days topical treatment medications were not administered. July 2007 Ammonium Lactate 12% Cream(GM) Apply to legs every day at 7:00 AM - 11 days topical treatment medications were not administered. August 2007 Ammonium Lactate 12% Cream(GM) Apply to legs every day at 7:00 AM - 21 days topical treatment medications were not administered. September 2007 Staff treatment MAR was not available for review. October 2007 Ammonium Lactate 12% Cream(GM) Apply to legs every day at 7:00 AM - 4 days topical treatment medications were not administered. Note: Client #1's Health Management Care Plan in the Skin as a risk area [decubitus ulcers] noted that "Staff are to document application of topical treatments on the MAR as per physician orders." 4. The facility failed to ensure its system for documentating the admnistration of Client #2's nutritional supplement was administered by the medication nurse in as evidenced below: On June 10 2007 the MAR reflected that Client #2 was not administered his dosage of Calcarb w	W 365	3. Staff has received additional training and instruction of the proper procedures for documenting topical treatment medications on the administration record. The treatment/topical medication administration record will be maintained in the MAR book as opposed to the program record for closer monitoring. Additionally the QMRP will review the treatment administration sheets weekly to monitor accurate documentation of topical medications. The Delegating RN will monitor the topical treatment records during the weekly review of the MAR documentation. Follow-up action as appropriate will occur in the event of repeated deviation from the approved medication administration procedures including suspension of medication administration privileges. 4. Further review of the MAR and discussion with staff revealed that the medication was omitted because it was not available at the time of medication administration. The Director of Health Services has provided all medication nurses and TME's addition training on accurate documentation of medication administration. Staff have been instructed on correct procedures for documenting a medication omission on the MAR. Training was completed on 10/30/2007. The delegating RN will review the MAR at least twice per month to monitor documentation. Follow-up action as appropriate will occur in the event of repeated deviation from the approved medication administration procedures including suspension of medication administration privileges.	10/30/07-Ongoing 10/30/07-Ongoing

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W 365	Continued From page 26 Vitamin D 600/200 tablet at 7:00 AM nor at 6:00 PM. There was no reason given by the medication nurse on the MAR.	W 365		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish an effective system to provide a training program for self-administration of medication for one of the two clients in the sample. (Client #2) The finding includes: Observation of the medication pass on October 10 2007 at approximately 5:05 PM, Client #2 participated in his self-medication objective by punching out his medications from the bubble packs provided by the medication nurse. Interview with the nurse and QMRP on October 11 2007 at approximately 3:30 PM revealed the medication nurse was responsible for implementing the self-medication objective in the evening and documenting the clients participation in the program on his data sheet in the MAR. Review of the MAR for the month of October failed to evidence that Client #2 self-medication objective had been implemented. Additionally, the observation of the Client #2 participating in his	W 371	Cross reference response to W252 on page 17/32.	10/30/07-Ongoing

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W 371	Continued From page 27 self-medication program on 10/10/07 in the evening was not recorded.	W 371		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, the facility failed to keep all drugs and biologicals locked securely when not being prepared for administration. The finding includes: The facility failed to ensure that each client's medications and topical treatment medications were secured in accordance with the agency's policy and procedures as evidence by the following: Observation on October 10, 2007 between 3:55 PM to 5:10 PM, revealed that the medication closet located in the kitchen was left open with the key in the door. During this period, direct care staff, clients and other agency personnel were entering and exiting the kitchen. It should be furhter noted that the house manager noticed the medication closet open upon his arrival into the facility. He then was observed to inform the Program Director and question if the the nurse in the facility. The House Manager at that time locked the closet and removed the key from the door.	W 382	Staff trained in medication administration will receive additional instruction in maintaining the security of medications. Staff are required to ensure that the medication cabinets are locked when medications are not being prepared. A notice staff of this protocol has been posted in a conspicuous location as a reminder for staff. The delegating RN and QMRP will randomly monitor medication passes to ensure medications remain secure at all times.	10/20/07
W 421	483.470(b)(4)(iv) CLIENT BEDROOMS	W 421		

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W 421	Continued From page 28 The facility must provide each client with individual closet space in the client's bedroom with clothes racks and shelves accessible to the client. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide clothes racks and shelves accessible for two of the four residing in the facility. (Client #1 and #3) The finding includes: On October 11, 2007 at 5:00 PM, Client #1 and #3 personal clothing were observed being stored in a hall closet outside of their bedroom. Interview with the Housemanager revealed that Client #1 and Client #3's did not have a wardrobe in their bedroom in order to store their personal clothing. Review of the inside labels of several shirts revealed clothing which belonged to Client #2. According to the House Manager, Client #2 had outgrown the items. However, the house manager was unable provide a copy of a personal property inventory documentation of these items had been given to either Client #1 or #3.	W 421	Client #1 and #3 have individual dressers and chest of drawers in their bedrooms which provide for ample clothing storage. The closet outside of the bedroom is a walk in closet that has been modified to be wheelchair accessible for Client's #1 and #3. A request to lower shelving/racks in the closet has been submitted to the Director of Operations. Maintenance contractor is scheduled to provide follow by 11/30/07. The personal property inventory for Client #2 has been updated to reflect the removal of the items that Client #2 has outgrown. Additionally, documentation reflecting Client #2's authorization to give these items to Client #1 and #3 has been obtained and placed on file in all applicable client records. The Residence Manager/QMRP will update personal property as personal items are purchased or discarded/given away. Residence manager/QMRP will obtain written consent from the Client when an exchange or donation of personal property has been requested.	11/30/07 10/21/07-Ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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W 436	Continued From page 29 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adaptive supports for three of the four clients residing in the facility. (Clients #1, #3 and #4) The findings include: 1. The facility's direct care staff failed to ensure that Client #3 was provided his adaptive gloves to protect his hands when propelling his wheelchair. Observation on October 10, and 11, 2007 revealed that Client #4 had the ability to mobilize his wheelchair independently. Interview with the staff and record review on October 12, 2007 revealed that Client #4 was to use protective gloves to reduce hand calloses. Interview with the house manager on October 11, 2007 at approximately 4:30 PM revealed that the adaptive support gloves were in the night stand in his bedroom. Review of Client #3's Physical Therapy assessment dated October 4, 2006 revealed a recommendation to continue the use of gloves for wheelchair propulsion as a measure to decrease calluses. At no time during the survey were direct care staff observed to encourage Client #3 to wear his gloves. 2. The facility's direct care staff failed to use Client #1 and Client #3's elevated tray consistently during each meal for independence. Observation of the breakfast on October 10, 2007 at 7:43 AM revealed Client #1 and Client #3	W 436	1. Cross reference response to W189 #1. 2. Cross reference response to W189 #2.	11/1/07-Ongoing

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W 436	Continued From page 30 eating independently using an adaptive built-up handle spoon and a high sided plates. Also observed using the meal was a large amount of spillage on the counter surface. Observation of the dinner at approximately 4:52 PM revealed Clients #1 and #3 eating independently with their adaptive plante on an elevated wooden tray. There was minimal spillage observed. Interview with the house manager confirmed that both of these clients were required to use a wooden riser during meals to bring the plate closer to them and to reduce spillage while eating. Review of Client #1's Occupational Therapy (OT) assessment dated 12/5/06 revealed a recommendation to continue to use an elevated tray for meals to reduce spillage and distance from plate to mouth. Review of Client #3's OT assessment dated 12/5/06 recommended that he should also continue to use an elevated tray to reduce distance plate to mouth. 3. On October 12, 2007 at 11:00 AM interview with the house manager revealed that Client #1 was required to wear support ted hose daily. Further interview with the house manager revealed that the client was not wearing ted hose at that time, and stated that Client #1's support hose were in this bedroom's side table drawer. Review of the Physical Therapist assessment dated September 28, 2006 reflected a recommendation that the client wear supportive hose on his lower extremities to reduce swelling during waking hours. At no time during the	W 436	3. Cross reference response to W189 #3.	11/1/07-Ongoing

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W 436	Continued From page 31 survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg edema.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of fire drill records, the facility failed to hold evacuation drills at least quarterly for each shift of personnel. The finding includes: Interview with the House Manager on October 12, 2007, at approximately 10:55 PM revealed that the staff shifts are as follows: Review of the fire drill log revealed that the facility failed to hold fire evacuation drills for all shifts at least quarterly. There were no fire drills conducted were required within the follow periods: 7:00 AM - 3:00 AM Monday through Sunday for the period of October 2006 to June 2007 These above findings were referred to the Office of the Fire Marshall.	W 440	Review of the fire drill record evidences that fire drills have occurred during the period of October 2006 to June 2007 between the periods of 7am-3am. A fire drill schedule is maintained in an effort to ensure that fire drills are conducted once monthly per shift. Fire drills will continue to occur during varied times and under varied conditions. Residence Manager and QMRP will review the fire drill records monthly to monitor completion of drills according to policies. Fire safety training will be conducted at a minimum of annually for all staff.	10/12/07-Onging

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 10, 2007 through October 12, 2007. A random sample of two clients was selected from a client population of four male clients with varying degrees of disabilities.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the prescribed modified diet are being monitored quarterly by a dietitian fore the two residents in the sample. (Resident #1 and #2) The findings include: On October 11, 2007 at approximately 1:40 PM, interview with the nurse and the review of Client #1's physician's order dated 9/1/07 revealed a 1500 calorie high fiber, low fat, low cholesterol diet. Further review of the order included prune juice or prunes for snacks, prune or apple juice daily and strictly follow nutritionist recommendations. There was no evidence that the nutritionist had assessed the client's since her April 11, 2007. Review of the April assessment recommended a diet order changed to 2000 - 2400 calories and bite size texture. These changes were not communicated to the primary care physician. Further review of his medical records failed to	I 043	Cross reference response to federal deficiency report citation W159 #2.	11/1/07

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I 043	Continued From page 1 evidence any additional quarterly monitoring was occurring by the nutritionist to ensure the correct modified diet was being implemented to meet Resident #1's nutritional needs.	I 043		
I 058	3502.16 MEAL SERVICE / DINING AREAS. A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review revealed that the facility's dietitian failed to conduct quarterly monitoring of special/modified diets. The findings include: The GHMRP failed to ensure that Resident #1 nutritional status was monitored quarterly as evidenced below: See Federal Deficiency Report Citation 3502.16	I 058	Cross reference response to federal deficiency report citation W159 #2.	11/30/07
I 077	3503.5 BEDROOMS AND BATHROOMS Each bedroom shall contain sufficient storage space for each resident ' s seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for Mentally Retarded Person (GHMRP) failed to ensure ample storage space	I 077	Cross reference response to federal deficiency report citation W421.	11/1/07

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I 077	Continued From page 2 in their bedroom for resident 's clothing for two of the four residents residing in the facility. (Resident #1 and #3) The finding includes: [See Federal Deficiency Citation W421]	I 077		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to maintain the facility in a safe,clean,orderly and sanitary manner. The findings include: Internal 1. The Chester drawer for Resident #1 was missing handles. 2. The Chester drawer for Resident #3 was missing handles. 3. The wall behind Resident #1 bed was damaged with streaks. 4. Resident #1 and #3 had no storage space in their bedroom for personal clothing. Their clothing was observed in a closet in the hallway outside of the bedroom,.	I 090	1. The missing handles on the Chester drawer for Resident #1 have been replaced. 2.. The handles on the Chester drawer for Resident #3 have been replaced. 3. The wall behind Resident #1's bed is scheduled to be repaired. 4. Cross reference response to federal deficiency report citation W421. Additionally, QMRP will ensure that weekly environmental inspections are completed by the Residential Director/Designee. All maintenance concerns will be forwarded to the Director of Operations and additional department heads as necessary for follow up action/correction of all maintenance concerns.	10/29/07 11/30/07 11/30/07

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I 090	Continued From page 3 External 1. The garage areas was being used for storage. 2. Lent from the dryer pipe was observed being propelled into the garage where abundance if items were being stored could be a possible fire hazard. 3. The light fixture in the garage were not operable. 4. Four (4) areas were observed to have buckled wood on ramp leading to the driveway and could be possible trip hazards. 5. The stairs leading from the driveway to the basement exit door had trash, debris and leaves which may create a drainage stoppage at the bottom of the stairs.	I 090	1. The garage is not utilized as a mode of egress in the event of an emergency. The items in the garage will be moved and stored in an alternative location. 2. The dryer exhaust will be re routed to expel lint outside of the home. The Director of Operations will secure a contractor to complete the necessary action. In the interim, the items have been moved out of range (10/17/07) of the dryer exhaust pipe to prevent a possible fire hazard. 3. The light fixture in the garage has been repaired. 4. The slats on the deck leading to the driveway are scheduled to be replaced. 5. The trash, debris and leaves on the stairs leading from the driveway have been removed. The stairs are swept on a daily basis to prevent accumulation of leaves and other debris that may blow in daily as a result of the seasonal climate changes. Additionally, QMRP will ensure that weekly environmental inspections are completed by the Residential Director/Designee. All maintenance concerns will be forwarded to the Director of Operations and additional department heads as necessary for follow up action/correction of all maintenance concerns to prevent potential environmental safety hazards.	11/30/07 10/29/07 11/30/07 11/30/07 10/12/07-Ongoing
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to lock caustic agents being stored. The finding includes: During the environmental walk-through on October 11, 2007 approximately 5:24 PM revealed the following; 1. Caustic agents were being stored over the washer and dryer unlocked.	I 095		

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I 095	Continued From page 4 2. The caustic agents storage cabinet with a variety of items was observed unlocked.	I 095	1-2. All caustic agents have been placed in a locked cabinet out of direct reach of the clients. Staff will be re-trained on the storage procedures for cleaning agents. Residence Manager will conduct a weekly environmental audit to ensure compliance with caustic agent storage procedures. QMRP will review all environmental audits and provide oversight as necessary to ensure compliance with environmental safety precautions.	
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill 4 times a year. The finding includes: See Federal Deficiency Report Citation W440	I 135	Cross reference response to federal deficiency report citation W440.	10/12/07
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to maintained each resident's funds received and disbursed. The findings include: See Federal Deficiency Report Citation W140	I 189	Cross reference response to federal deficiency report citation W140 #1-3.	11/1/07-Ongoing
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.	I 203	See response to L203 on page 6/13.	

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I 203	Continued From page 5 This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on October 12, 2007 at 1:20 PM, revealed that GHMRP failed to provide evidence of current signed job descriptions for three(3) direct care staff [[redacted] and [redacted]].	I 203	Employees updated Job Descriptions have been placed on file. QMRP/Residence Management will maintain a list of all employee hire dates and review Job Descriptions with employees on an annual basis. The Human Resources Assistant will review the job descriptions with new employees upon hire during the first day of orientation. Evidence of the Job Description review will be maintained in the employee's personnel records. Personnel records will be audited routinely by the Director of Programs and the Human Resources Assistant to ensure compliance with annual review requirements.	11/1/07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform their required duties. The findings include: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's	I 206	Notification of all outstanding health certificates for all staff and consultants have been distributed to all applicable employees with a deadline for submission of 11/15/07. Director of Operations/Human Resources will send maintain a list of the expiration dates for all health certificates for all employees. Staff/consultants will be notified of the need to submit a current health certificate within 60-days of the current one's expiration.	10/17/07-Ongoing

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I 206	Continued From page 6 personnel files on September 12, 2007 at 1:10 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for twelve (12) staff and nine (9) consultants.	I 206		
I 212	3509.9(d) PERSONNEL POLICIES Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (d) Conviction for a sexual offense or violent crime. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that employment references on each employee were free from a history of a violent crime. The finding includes: Review of the personnel records on October 12, 2007 at 1:00 PM revealed that the GHMRP evidence one criminal background checks which disclosed that Staff #1([redacted]) was employed by the agency on October 4, 2006 with a history of a violent crime. Although Staff #1 background check revealed a Felony charge on his record with two counts associated with a violent offenses, this direct care staff was hired by the agency to work with vulnerable clients in this group home setting.	I 212	Review of the personnel records indicate that the referenced employee ([redacted])'s Felony charge was over fourteen years old. A request for [redacted] to have the charge expunged from his criminal has been made by Human Resources. Mr. [redacted] has been an employee in good standing since his hire date in 2003. The statue of limitations according to DC law is seven years. The agency does and will not employ individuals who have a history of sexual offense or violent crimes which occur within the statute of limitations. The agency will continue to ensure that criminal background checks are completed according to regulatory requirements.	10/12/07-Ongoing

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I 229	Continued From page 7	I 229		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure staff were trained. The finding includes: Review of the in-service training records on October 12, 2007, revealed the GHMRP failed to provide training in communication, dental hygiene and assistive technology. Also See Federal Deficiency Citation W189	I 229	Further review indicated that additional staff training records were on file at the Administrative office. All staff has received training in communication, dental hygiene and assistive technology. Verification of staff training is maintained on file in the Administrative Office. The Directors of Operations and Programs will duplicate the staff training records that are on file in the Administrative office and place copies of the records in the homes to ensure availability for review by monitoring agencies.	11/1/07
I 370	3519.1 EMERGENCIES Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death. This Statute is not met as evidenced by: Based on observation , interview and record review the GHMRP failed to ensure that the staff and nursing personnel followed the agency policies and procedures on emergencies. The finding include:	I 370	Cross reference responses to federal deficiency report citations W153 & W154.	11/1/07

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I 370	Continued From page 8 See Federal Deficiency Report Citation W153 and W154	I 370		
I 392	3520.2(b) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (b) Dentistry; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the necessary dental evaluations and treatment services for one of two residents in the sample. (Resident #2) The finding includes: See Federal Deficiency Report Citation W352	I 392	Cross reference response to federal deficiency report citation W352.	10/17/07-Ongoing
I 396	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be	I 396		

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I 396	Continued From page 9 necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (f) Occupational Therapy; This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that current The finding includes: Review of the consultants filed failed to evidence that the Occupational Therapist had current license on file at the time of the survey.	I 396	The current license for the Occupational Therapy Consultant has been obtained and filed in the applicable personnel record. Program Director/Human Resources will ensure that professional licenses are up to date and maintained on file Director of Operations/Human Resources will send maintain a list of the expiration dates for all consultant professional licenses. Consultants will be notified of the need to submit a current license within 30-days of the current one's expiration.	10/22/07-Ongoing
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review of the consulting professional records the GHMRP failed to have current Speech Language license	I 399	See response to L399 on next page 11/13.	

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I 399	Continued From page 10 on file in the facility. The finding includes: Interview with the Residence Director and review of the personnel files on October 12, 2007 at 1:50 PM failed to evidence that the Speech Language Therapist has a current license on file.	I 399	The current license for the Speech and Language Pathologist Consultant has been obtained and filed in the personnel record. Director of Operations/Human Resources will send maintain a list of the expiration dates for all consultant professional licenses. Consultants will be notified of the need to submit a current license within 30-days of the current one's expiration.	10/22/07-Ongoing
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provided diagnosis, evaluation, treatment services and necessary follow up service to prevent deterioration or further loss of functioning for each resident in the facility. The findings include: See Federal Deficiency Report Citation W322, W331 and W352	I 401	Cross reference responses to federal deficiency report citations W322, W331 and W352.	
I 402	3520.4 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include an annual health inventory of each resident. This Statute is not met as evidenced by: Based on interview and record review the	I 402	See responses to L402 on the next page 12/13.	

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I 402	Continued From page 11 GHMRP failed to provide a annual physical evaluation for one of two residents in the sample. The findings include: See Federal Deficiency Report Citation W322	I 402	Cross reference response to federal deficiency citation W322.	11/1/07
I 470	3522.1 MEDICATIONS Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq. This Statute is not met as evidenced by: Based on observation, Interview and record review, the GHMRP Trained Medication Employee failed to implement the agency policies and procedures for administering each Resident's medication regimen. The findings includes: See Federal Deficiency Report Citation W104, W189, and W352	I 470	Cross reference responses to federal deficiency report citation W104, W189 & W352.	10/17/07-Ongoing
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP's nursing staff failed to ensure medication administration records were without documentation error.	I 474	Cross reference response to federal deficiency report citations W331, W352, W365 and W382.	10/17/07-Ongoing

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L474	Continued From page 12 The finding includes: Refer to Federal Deficiency Report W331, W352, W365 and W382.	L474	See responses to L474 on previous page 12/13.	